PSYCHEALTH, LTD.

Outpatient Utilization Review and Request for Authorization of Services

PLEASE FILL IN ALL AREAS OF THIS FORM **COMPLETELY AND LEGIBLY** TO EXPEDITE PROCESSING OF AUTHORIZATIONS. **We encourage all behavioral healthcare providers to coordinate care with the member's Primary Care Physician.** If you need assistance in doing so, please contact PsycHealth @ 847.864.4961. FAX COMPLETED FORMS TO: **847.864.9930**

Patient's Name: _____
Patient's Insurance Plan: (**Please specify**): _____
Patient's Insurance ID #: _____
Provider's Name and Credentials: _____

Primary Care Physician (PCP): _____
Contact with member's PCP to coordinate integrated care? Yes____ No____ Date of contact: _____

Date member first contacted: ___/___/___ Scheduled initial session on: ___/___/___
Actual initial session (if different from scheduled date): ___/___/___
Most Recent Session: ___/___/___
Number of Sessions to Date: ____
Expected Number of Sessions to Complete this Treatment Course: ____

Diagnosis and **DSM-IV Code**:_____

Symptoms:_____
_____

Treatment Plan and Frequency of Sessions: _____
_____
_____
_____

Progress of Tx (Do not complete for Initial Review): _____
_____
_____

Medications (Including dosage): _____
_____

Therapist's Name:_____

Psychiatrist's Name:_____

Signature/Title: _____ Date: _____

Disposition (For PsycHealth Personnel Use Only):
_____
_____
_____

PLEASE NOTE THAT AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT